(2) A nursing home with 100 or more beds must employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is an individual with—

(i) A bachelor's degree in social work from a school accredited by the Council of Social Work Education (Note: A master's degree social worker with experience in long-term care is preferred), and

(ii) A social work license from the State in which the State home is located, if offered by the State, and

(iii) A minimum of one year of supervised social work experience in a health care setting working directly with individuals.

(4) The facility management must have sufficient support staff to meet patients' social services needs.

(5) Facilities for social services must ensure privacy for interviews.

(i) *Environment.* The facility management must provide—

(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

(3) Clean bed and bath linens that are in good condition;

(4) Private closet space in each resident room, as specified in §51.200(d)(2)(iv) of this part;

(5) Adequate and comfortable lighting levels in all areas;

(6) Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71–81 degrees Fahrenheit; and

(7) For the maintenance of comfortable sound levels.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

§51.110 Resident assessment.

The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) *Admission orders.* At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.

(b) *Comprehensive assessments.* (1) The facility management must make a comprehensive assessment of a resident's needs:

(i) Using the Health Care Financing Administration Long Term Care Resident Assessment Instrument Version 2.0; and

(ii) Describing the resident's capability to perform daily life functions, strengths, performances, needs as well as significant impairments in functional capacity.

(iii) All nursing homes must be in compliance with the use of the Health Care Financing Administration Long Term Care Resident Assessment Instrument Version 2.0 by no later than January 1, 2000.

(2) *Frequency.* Assessments must be conducted—

(i) No later than 14 days after the date of admission;

(ii) Promptly after a significant change in the resident's physical, mental, or social condition; and

(iii) In no case less often than once every 12 months.

(3) *Review of assessments.* The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(4) *Use.* The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.

(c) *Accuracy of assessments.* (1) Coordination—

(i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment.

(2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(d) *Comprehensive care plans.* (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 51.120; and

(ii) Any services that would otherwise be required under § 51.120 of this part but are not provided due to the resident's exercise of rights under § 51.70, including the right to refuse treatment under § 51.70(b)(4) of this part.

(2) A comprehensive care plan must be—

(i) Developed within 7 calendar days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(e) *Discharge summary.* Prior to discharging a resident, the facility management must prepare a discharge summary that includes—

(1) A recapitulation of the resident's stay;

(2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

§ 51.120 Quality of care.

Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Reporting of Sentinel Events*—(1) *Definition.* A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or

(ii) Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or

(iii) Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or

(iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or

(v) Assault, homicide or other crime resulting in patient death or major permanent loss of function; or

(vi) A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

(3) The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1–22) and Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114) within 24 hours of notification.

(4) The facility management must establish a mechanism to review and